

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02273						02269					
<b>1. PLACE OF DEATH</b> e. COUNTY <u>Howard</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> c. LENGTH OF STAY IN 1b <u>25 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shaffer's Convalescent Retreat</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u> d. STREET ADDRESS <u>Federal Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Maude Irene Brookhart</u>			<b>4. DATE OF DEATH</b> <u>February 19, 1967</u>			<b>5. SEX</b> <u>Female</u>			<b>6. COLOR OR RACE</b> <u>White</u>		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>9/22/1885</u>			<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.			<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Jarrettsville, Md.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>Columbus Preston</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Kunkle</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>214-34-4034D</u>			<b>17. INFORMANT</b> <u>Mrs. Louise Putnam</u>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) <u>10th</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10th</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> (County) (State)			<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1-22</u> <u>1965</u> , to <u>2-19</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>2-18</u> <u>1967</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.		
<b>22a. SIGNATURE</b> <u>Thomas F. Herbert</u> M.D.			<b>22b. DATE</b> <u>2-19-67</u>			<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Thomas F. Herbert, MD</u>			<b>22d. ADDRESS</b> <u>Ellicott City Md. 21043</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>2/22/1967</u>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Jarrettsville</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Jarrettsville, Maryland</u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Kurtz</u>			<b>24b. ADDRESS</b> <u>Jarrettsville, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>FEB 21 1967</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

21084

03333

03333

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

OFFICE OF VITAL RECORDS AND STATISTICS

1. Name of deceased  
2. Sex  
3. Race  
4. Date of birth  
5. Date of death  
6. Place of birth  
7. Place of death  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar  
11. Date of registration

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02274

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02270

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>109 TAKOYA DR.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy Clinton Fries</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 22, 1907</b>	
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13. BIRTHPLACE (State or foreign country) <b>VA.</b>		14. CITIZEN OF WHAT COUNTRY?	
15. FATHER'S NAME <b>GEORGE C. FRIES</b>		16. MOTHER'S MAIDEN NAME <b>BESSIE E. THARP</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO.	
19. INFORMANT <b>Lillian Fries</b>		Address <b>109 TAKOYA DR. ELICOTT CITY, MD.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c) <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
29. ACTUAL SIGNATURE <b>George E. Burtorf</b> EXAMINER'S NAME (Type) <b>George E. Burtorf, M.D.</b>		30. DATE SIGNED <b>2-14-67</b>	
31. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		32. DATE THEREOF <b>2-16-67</b>	
33. NAME OF CEMETERY OR CREMATORY <b>EDGE HILL CEM.</b>		34. LOCATION (City or Town) (County) (State) <b>CHARLESTOWN CLARKE</b>	
35. FUNERAL DIRECTOR <b>Ed. J. ...</b> ADDRESS <b>Ellicott City</b>		36. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>FEB 17 1967</b>	
37. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		38. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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THE UNIVERSITY OF CHICAGO

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, give page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

02275

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02271

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dailey - Rural</u> c. LENGTH OF STAY IN lb <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>George Wilson Farm - Jennings Chapel Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dailey Rural</u> d. STREET ADDRESS <u>Jennings Chapel Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Raymond Luther JUNKINS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1967</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-8-1905</u>		9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>13</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>				11. BIRTHPLACE (State or foreign country) <u>Howard Co Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM BRUCE JUNKINS</u>				14. MOTHER'S MAIDEN NAME <u>ELLA MAY STOFFEL</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>219-44-5691</u> 17. INFORMANT Address <u>MRS. George G. Wilson Jennings Chapel Rd</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic Cardiovascular Disease</u> (c) <u>2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>George E. Burgette</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>2-3-67</u>					
EXAMINER'S NAME (Type) <u>GEORGE E. BURGETTE M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-6-67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Camel</u>				22d. LOCATION (City, town, or country) (State) <u>Sunshine, Md.</u>			
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 7 1967</u>		24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

ESSO

3550

• 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 8

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Francis H. Carter, Governor of Maine, 1959-1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

02276

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02272

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Montgomery Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JULIA CORONA KRAMER</b>		4. DATE OF DEATH Month Day Year <b>Feb. 28, 1967 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-10-1892</b>
9. AGE (in years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Catonsville, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Fiedler</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Weiser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-28-2962 B</b>	
17. INFORMANT <b>Mr. Paul Kramer, Landing Road, ElkrIDGE, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1551 Carcinoma Gall Bladder</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 8, 1966</b> to <b>Feb 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 24, 1967</b> , and that death occurred at <b>7:45</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Karl F. Mech, M.D.</b>		22b. DATE SIGNED <b>2/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Karl F. Mech</b>		22d. ADDRESS <b>3350 Wilkins Ave. Baltimore, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-3-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City, town or county) (State) <b>Ilchester, Md</b>	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

02277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02273

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> <b>13-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Marydell Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WESLEY CHARLES O'HARA</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1926</b>
9. AGE (In years last birthday) yrs. <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician-Teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank M. O'Hara</b>		14. MOTHER'S MAIDEN NAME <b>Alma V. Updyke</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <b>yes W.W. 2</b>		16. SOCIAL SECURITY NO. <b>219-22-5799</b>	
17. INFORMANT <b>Mrs. Rosemary W. O'Hara</b>		Address <b>5 Marydell Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>February 13, 1967</b>	
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>February 13, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-17-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>G. Howard Strong 3207 W. North Ave.,</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Springate</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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02278

## CERTIFICATE OF DEATH

02274

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. LENGTH OF STAY IN lb <u>38 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 4 Box 220</u>				d. STREET ADDRESS <u>Rt 4 Box 220</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eugene A.</u> Middle <u>Perrey</u> Last <u>Perrey</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23, 1886</u>		9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>flower grower wholesale plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>France</u>		11. BIRTHPLACE (County & State, or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Joseph Perrey</u>				14. MOTHER'S MAIDEN NAME <u>Melina V. Prast</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-36-5346</u>		17. INFORMANT <u>Jules S. Perrey Jessup Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary-Vascular disease</u> DUE TO (c) <u>Senility &amp; infirmities of age</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>Feb 13</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Feb 12</u> 19 <u>67</u> , and that death occurred at <u>4:12</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>B B Brumbaugh</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>				22d. ADDRESS <u>7609 Main St Elkridge 27 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Darkey Md</u>	
24. FUNERAL DIRECTOR <u>Witt Canadian, Laurel Md</u>				25a. REC'D BY REGISTRAR <u>Feb 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02279

## CERTIFICATE OF DEATH

02275

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u> 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SIMONS REST HOME</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ADELAIDE AMELIA SHENE</u>		4. DATE OF DEATH <u>FEBRUARY 24 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 18 1876</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Smith Broadway</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Knapp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>7</u>	
17. INFORMANT <u>Mrs Sam Cheney W. Va.</u>		Address <u>Martinsburg</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 YRS.</u> (c) <u>5 DAYS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>BRONCHO PNEUMONIA</u> <u>5 DAYS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>64</u> , to <u>2/24</u> , 19 <u>67</u> , that (I) <u>was</u> saw the deceased alive on <u>2/22</u> 19 <u>67</u> , and that death occurred at <u>7:00</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Charles S. Whitaker</u>		22b. DATE SIGNED <u>2/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER</u>		22d. ADDRESS <u>CLARKSVILLE, MD 21029</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Ligand Md.</u>
24. FUNERAL DIRECTOR <u>Delwill Dannehan</u>		25a. REC'D BY REGISTRAR <u>Laurel Mt</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 1 1967</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7 Film G386 3/1/67 mh  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02280

02276

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. LENGTH OF STAY IN 1b <b>30-4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B &amp; O track 1/2 mile east of Hanover Rd. cross- ing</b>			d. STREET ADDRESS (last known) <b>1029 E. Baltimore Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Edward SIMPSON</b>			4. DATE OF DEATH Month Day Year <b>pronounced February 3, 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Unknown</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1912</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>IF UNDER 24 HRS.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNK.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNK.</b>		11. BIRTHPLACE (State or foreign country) <b>UNK.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>UNK.</b>		
14. MOTHER'S MAIDEN NAME <b>UNK.</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>UNK.</b>			17. INFORMANT <b>AW. Middlecamp.</b>		
18. ADDRESS <b>3900 Lock Raven Blvd.</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> DUE TO (b) <b>802X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Run over by train</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute ethylism</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Run over by train</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2/2</b> or <b>2/3</b> 19 <b>67</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>railroad tracks</b>	
20f. (City or town) (County) (State) <b>HOWARD MARYLAND</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <b>February 3, 1967</b>		23. ACTUAL SIGNATURE <b>Charles S. Petty, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NAT'L Cem.</b>	
23d. LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Morton E Dyett F.H. 1701 Laureus St.</b>			
25a. REC'D BY REGISTRAR DATE <b>Feb 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Petty</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02281

02277

1. PLACE OF BIRTH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>414 North Laurel Road</u>		d. STREET ADDRESS <u>414 N. Laurel Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Warren Taylor</u>		4. DATE OF DEATH <u>Feb. 17 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 1949</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>Riverdale Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. Clifton Taylor</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE INGRAM Thelma I Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Walter Clifton Taylor</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> DUE TO <u>089X</u> Branch pneumonia DUE TO <u>Mumps</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1</u> <u>5</u> <u>6</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 18, 1949</u> to <u>Feb 17, 1967</u> that (I) (we) last saw the deceased alive on <u>Feb 17, 1967</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert S. McCeney</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT S. MCCENEY</u>		22d. ADDRESS <u>LAUREL, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Fulton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Witt Danaher</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1967</u>	
ADDRESS <u>Laurel, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Chambers</u>	

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